

JAN 2 1935

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

✓ 42640  
File No. 638  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

1. PLACE OF DEATH

County Greene Registration District No. 318  
Township \_\_\_\_\_ Primary Registration District No. 2001  
City Springfield (No. St. John Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

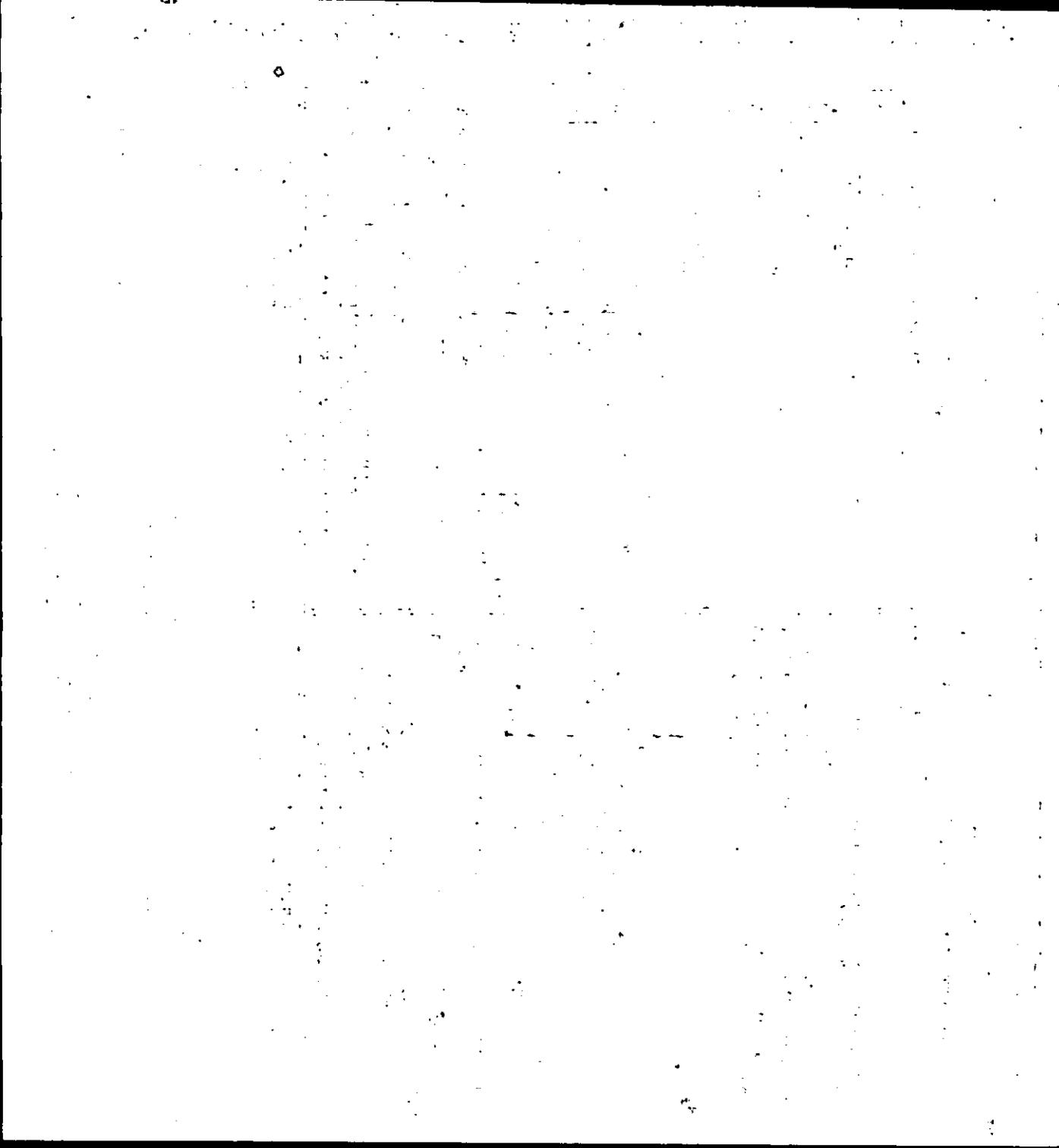
3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 15 - 1873  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
61 5 7  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Madison Co. Mo  
13. NAME C. H. Green  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn  
15. MAIDEN NAME Mary A. Buckfill  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn  
17. INFORMANT Mrs. Syre James  
(ADDRESS) Madison Mo  
18. BURIAL, CREMATION, OR REMOVAL Union Home DATE Dec 23  
19. UNDERTAKER McMahan Funeral Service  
(ADDRESS) Madison Mo  
20. FILED 12-25 1934 Springfield Mo

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 22, 1934  
22. I HEREBY CERTIFY, That I attended deceased from 12/13, 1934, to 12/22, 1934  
I last saw him alive on 12/21, 1934 Death is said to have occurred on the date stated above, at 6:00 a.m.  
The principal cause of death and related causes of importance were as follows:  
R. Lobar Pneumonia  
following  
electro-transcatheter  
section 12/14/34  
Other contributory causes of importance: \_\_\_\_\_  
Date of onset \_\_\_\_\_  
Name of physician Pauline Wilson Date of 12/14/34  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? Yes  
23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_  
24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify \_\_\_\_\_  
(Signed) W. J. Wilson, M. D.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Greene Registration District No. 918  
Township Springfield Primary Registration District No. 2091  
City St. John Hope (No.         )

File No. 42640  
Registered No. 638  
St.          Ward         

**2. FULL NAME**

(a) Residence, No.          St.          Ward         

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX m 4. COLOR OR RACE m 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 22, 1934

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from         , 19        , to         , 19        .  
I last saw          alive on         , 19        . Death is said to have occurred on the date stated above, at         .

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

Benign Hypertrophy - Urinary Retention  
Date of onset         

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)

**DECLARATION**

Other contributory causes of importance:         

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Prostatic Action  
Name of operation          Date of         

13. NAME

What test confirmed diagnosis?          Was there an autopsy?         

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?          Date of injury         , 19        

15. MAIDEN NAME

Where did injury occur?           
(Specify city or town, county, and State)

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Specify whether injury occurred in industry, in home, or in public place.  
Manner of injury           
Nature of injury         

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

24. Was disease or injury in any way related to occupation of deceased?           
If so, specify         

PLACE          DATE         , 19        

19. UNDERTAKER (ADDRESS)

(Signed)         , M. D.  
(Address)         

20. FILED 12/25, 1934  
Robert H. [Signature]

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

APR 1 3 1965

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